West Location: 3540 Stewart Ave, Suite A, Wausau, WI 54401 | Fax-715-843-7761
East Location: 1915 N6th Street, Suite C, Wausau, WI 54403 | Fax-715-870-2208
Phone 715-842-3999

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name (Print): _____ Date of Birth: _____

Previous/Maiden Name (if applicable): _____ Phone: (____) _____

Facility/Provider Authorized to Disclose (Releasing Entity):

Name: _____
Address: _____
City/State/Zip _____
Fax #: _____

Facility/Provider Authorized to Receive or Use (Receiving Entity):

Name: _____
Address: _____
City/State/Zip _____
Fax #: _____

Information to be Disclosed includes copies of:
____ **Entire Record or Partial Record Including:**

____ Patient Intake Forms (History) _____ Daily Chart Notes
____ Physical Examination Forms _____ X-ray Reports
____ Plan of Treatment forms _____ X-ray Films (copies)
____ Consultations/Report of Findings _____ Discharge Summary
____ Other, specify: _____

Purpose for Disclosure:
_____ Treatment, Payment or Operations **or** _____ Other (Specify):_____

Expiration: This authorization will expire (select **one**):
_____Transfer of records is for Treatment purposes, expiration not applicable.
_____On _____/_____/_____
_____On the occurrence of the following event: _____

Right to Revoke:
I understand that I have the right to revoke this authorization in writing by presenting the revocation to the clinic manager @ Bautch Chiropractic listed above. I understand that revocation will not apply to information that has already been released prior to written revocation.

Signature:
I understand that the facility cannot condition treatment of whether I sign this authorization. I understand that authorizing the disclosure of this health information is voluntary and I may refuse to sign the authorization. A copy of this authorization is as valid as the original.

Patient Signature: _____ Date: _____
Legal Representative (if applicable)
Name (Print): _____
Relationship to Patient: _____
Legal Representation Signature: _____ Date: _____
If signing for a minor patient, I hereby state that my paternal rights have not been revoked by a court of law.